

PATENT APPLICATION

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**MODULAR ADJUSTABLE PROPHYLACTIC
HIP ORTHOSIS AND
ADDUCTION/ABDUCTION JOINT**

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MODULAR ADJUSTABLE PROPHYLACTIC HIP ORTHOSIS AND ADDUCTION/ABDUCTION JOINT

BACKGROUND OF THE INVENTION

5 1. Field of the Invention

The present invention is directed to an orthotic brace and, more particularly, to an orthosis having modular component parts, such as a hip orthosis, that can address the postoperative treatment of a patient following hip arthroplasties.

2. Description of Related Art

10 Orthotic management of hip joint compromise has been a challenge for orthopaedics, orthotists, and therapists when dealing with patients whose hip joints and their associated soft tissues, joint integrity, alignment, and bone and capsular components are compromised. A hip is a multidirectional joint capable of flexion, extension, internal and external rotation, adduction, and abduction. In addition to its
15 mobility, the hip joint must absorb the force of full weight-bearing and provide stability to the pelvis both for standing and for single support during gait. Additionally, during walking, while one hip is stabilized, the opposite leg must have the strength, range of motion, and structural integrity to advance.

The hip joint is a synovial ball and socket joint that consists of the articulation
20 of the spherical head of the femur with the cup-like shape of the acetabulum. An

acetabular labrum attaches to the bony rim of the acetabulum and cups around the head of the femur to hold it firmly in place. Various ligaments add strength to the articulation of the hip joint and a large number of muscles act on the hip joint. The gluteus medius is primarily associated with abduction. Anterior fibers assist with flexion and internal rotation. Posterior fibers assist with extension and external rotation. These muscle groups stabilize the pelvis during a single leg support.

Frequently, these muscle groups are compromised when surgical procedures are performed at the hip joint, especially during a hip replacement surgery. A significant problem that occurs when a hip joint has been compromised is dislocation of the hip joint. Thus, the femoral head can be driven out of the acetabulum. The hip is most susceptible to posterior dislocation when it is flexed past 90°, internally rotated and adducted. Examples of this action occur in every day living, such as sitting on a low chair and leaning forward while putting weight on the affected hip joint and internally rotating when coming to a standing position. Thus, common activities of daily living, specifically excessive hip flexion with loaded extremity and internal rotation on the affected side, can cause dislocation. Anterior dislocation also occurs when a hip is externally rotated, abducted, and flexed and if, for example, a knee is subject to a force, such as accidentally hitting an object. The neck of the femur or the greater trochanter levers the femur out of the acetabulum. To avoid these problems, an orthosis must be able to effectively control the limits of extension and rotation in a patient who has experienced an anterior dislocation.

The assignee of the present invention has provided orthoses to control extension and external rotation with a line of "NEWPORT®" hip system products.

See, for example, Team Management of Hip Revision Patients Using a Post-Op Hip Orthosis by Lima et al., Journal of Prosthetics and Orthotics, Vol. 6, No. 1, Winter/1994.

An example of an orthotic hip support can be found in U.S. Patent
5 No. 5,830,168, while a safety device to assist movement of a person can be found in U.S. Patent No. 5,361,418. An orthopedic hip and leg abductor is disclosed in U.S. Patent No. 5,361,418.

As the median age of the population becomes older, there are more occasions for the treatment of hip disorders and there is still a need to improve the function of
10 such orthoses and their component parts in this medical field in an economical manner, while addressing a comfort level for the patient to encourage maximize prolonged usage.

SUMMARY OF THE INVENTION

The present invention is directed to a modular orthosis and to improvements in
15 pre-fabricated component parts of the modular system for not only a hip orthosis, but for other broader applications in the orthotic field.

The orthosis can include a pelvic or hip engaging unit that is formed to conform to the contours of a human hip. This hip engaging unit can include multi-positional joints which can enable expansion, contraction, and rotation to permit a
20 prefabrication of the hip engaging unit and a subsequent adjustment to the particular anatomy of the patient. The hip engaging unit can include first and second rigid outer hip engaging members with a relatively flexible rear connector plate adjustably

interconnecting the first and second hip engaging members. A closure system can securely mount the hip engaging unit on the patient. The connector plate can have a bridge member extending vertically upward and across a hip band member to not only stiffen the connector plate from relative rotational movement, but also to provide a handle to permit an orthotist, a therapist or family care provider to assist in training the patient in the use of the orthosis.

An adjustable support plate assembly can be connected to an anchor location on the hip engaging unit. The support plate can have a securement portion adjacent the anchor location with a curved configuration to enable an adjustable movement of a distal end towards and away from the user. The distal end of the support plate can in turn be connected to an appendant orthotic member which can encircle and restrain movement of the leg of the patient.

Preferably, an adjustable hinge unit is provided to enable a range of both flexion and abduction movement. In one embodiment of the invention, an adjustable linkage system can extend across an articulated joint to permit a setting of a range of abduction that can vary with flexion. Flexion can be controlled with a variable setting hinge member. A link member that can be adjusted in length is pivotally affixed on either side of the articulated joint. The link member can be fixed at a location offset from a first rotational axis of the hinge member. The articulated joint has a second rotational axis which can be offset approximately 90° from the first rotational axis of the hinge member, whereby movement about the first rotational axis will cause movement of the articulated joint about the second rotational axis. Since the hinge member is adjustable to control the range of flexion and extension and the link

member is adjustable to control adduction and abduction, a controlled compound motion is afforded the patient.

An alternative adjustable hinge unit can utilize a variable setting hinge member with a pivotal joint member connecting the hinge member to a bar that is
5 attached to the appendant orthotic member. A follower roller and cam member can control the bar's movement in adduction and abduction as the hinge member permits the hip joint to flex and extend.

The appendant orthotic member can be pre-fabricated in the form of a sleeve member or diagonal semi-rigid cylindrical band that can be adjusted in dimension to
10 fit the thigh and knee portion of the patient. The sleeve member is formed of a relatively rigid plastic with a degree of flex and adjustable joints are provided for varying an encircling dimension of the sleeve member on the appendage to provide a custom fit for the user. Since the outer upper side of the sleeve member is longitudinally displaced from an opposite lower portion adjacent the knee,
15 corresponding fixation points are provided to prevent rotational displacement of the sleeve member about the leg. Appropriate resilient pads can be removably fastened to both the hip engaging unit and the appendant sleeve member to directly bear against the patient's body.

BRIEF DESCRIPTION OF THE DRAWINGS

20 The objects and features of the present invention, which are believed to be novel, are set forth with particularity in the appended claims. The present invention, both as to its organization and manner of operation, together with further objects and

advantages, may best be understood by reference to the following description, taken in connection with the accompanying drawings.

Figure 1 is a front perspective view of the modular component parts formed in a hip orthosis of the present invention;

5 Figure 2 is a side perspective view of the hip orthosis in a setting position;

Figure 3 is a rear elevated view of the hip orthosis;

Figure 4 is a perspective view of the hip engaging member;

Figure 5 is a cross-sectional view of an anchor location on the first hip engaging member;

10 Figure 6 is a plan view of an adjustable hinge unit;

Figure 7 is a side view of the adjustable hinge unit;

Figure 8 is a perspective view of the adjustable hinge unit;

Figure 9 is a perspective view of an appendant orthosis for attachment to a leg of a patient;

15 Figure 10 is a partial exploded view of the appendant orthosis of Figure 9;

Figure 11 is a side view of an alternative embodiment of an adjustable hinge unit; and

Figure 12 is a plan view of the alternative embodiment.

DETAILED DESCRIPTION

20 OF THE PREFERRED EMBODIMENTS

The following description is provided to enable any person skilled in the orthotic art to make and use the invention and sets forth the best modes contemplated by the

inventors of carrying out their invention. Various modifications, however, will remain readily apparent to those skilled in the art, since the general principles of the present invention have been defined herein specifically to provide an improved modular component orthosis which can be combined together to form an adjustable prophylactic
5 hip orthosis and adduction/abduction joint.

The modular components of the present invention can be combined together to provide an orthosis that can be pre-fabricated and subsequently adjusted to meet the specific needs and sizes of various patients. Thus, the cost of customized orthoses can be avoided while retaining the advantages of a customized fitting to meet the specific
10 needs of the patient. The utilization of the various modular components can be advantageously incorporated in different types of orthotic applications, since individually they each represent improvements in design and function. Collectively, the modular components can advantageously provide an improved orthosis.

A particular example of such an orthosis is an adjustable prophylactic hip
15 orthosis and abduction joint. While the present invention is described in this environment, it should be readily appreciated that the metes and bounds of this invention are not so limited, since one or more of the modular components can be advantageously utilized in other orthotic applications. For example, the hip engaging unit of the present invention can be utilized to provide a stable platform for supporting
20 orthoses treating shoulder and arm appendages. Likewise, it can provide a stable platform for other orthoses, such as an orthopaedic leg abductor for resisting muscular contraction of the type disclosed in U.S. Patent No. 5,814,001 and incorporated herein. Another example of an orthosis that can utilize component parts of the present

invention, such as the hip engaging unit, the adjustable support plate, and the connector plate, can be seen in orthopaedic shoulder braces having adjustable pelvic and arm supports shown, for example, in U.S. Patent No. 5,538,499 and U.S. Patent No. 5,487,724 which are incorporated herein by reference.

5 Referring to Fig. 1, an embodiment of the present invention is disclosed as an adjustable hip orthosis 200. The adjustable hip orthosis is created from pre-fabricated modular component parts that can be custom-adjusted to match the particular size of the patient and the prescribed range of motions permitted for that patient, including flexion, extension, adduction, and abduction.

10 The hip orthosis 200 includes a pelvic or hip engaging unit 10, as shown in Fig. 4, having a first hip engaging member 12 and a second hip engaging member 14. Each of the hip engaging members 12 and 14 include a relatively rigid plastic shell of a shape to capture and conform to a side of a patient's hip and leg. The plastic can be a high or low density polyethylene, a polypropylene or co-polymers thereof, which can be
15 heat-molded into a shape which conforms to the contours of the average human hip. Removable resilient pads 3 such as neoprene, polyurethane foam or polyethylene foam or other medically acceptable resilient pads are mounted within each hip engaging member to provide comfort to the user.

 A flexible plastic connector plate 16 has a pair of elongated slots 18 and 20. An
20 abrasive, gritted, knurled or cross-hatched surface 34 can extend peripherally around the respective elongated slots 18 and 20. An abrasive tape or patch can be adhered about the slots 18 and 20 to provide the textured surfaces. By providing such a friction textured surface, both on the connector plate 16 and on a matching surface of the

respective first hip engaging member 12 and the second hip engaging member 14, both horizontal and relatively rotational adjustments can be made for a customized fit on the patient and then a subsequent compressive tightening by the fasteners 22 and 24, which extends through the respective slots 18 and 20, can lock these respective joints into place
5 without the need for incremental settings. A tool, such as an Allen wrench (not shown), may be utilized to tighten the fasteners. As can be appreciated, neoprene pads can be attached, for example, by a hook and nap material 7, such as Velcro®, to the interior of the hip engaging unit 10.

A strap 26 can be anchored on the first hip engaging member 12 and can have an
10 adjustable buckle 28 attached to the strap 26. Another strap 36 is anchored on the second hip engaging member 14 with a buckle engaging member 29 at the other end. Additionally, a hook and nap fastener unit with the nap material being provided on the strap 36 and the hook material being provided adjacent the anchor point to the first hip engaging member 12 permits the hip engaging unit 10 to be adjusted and removably
15 fastened to the user.

The connector plate 16 adjustably interconnects the first and second hip engaging members 12 and 14 and further includes a bridge member 30 extending vertically upward and across a lower band member 38 of the connector plate 16. Thus, the connector plate 16 has the lower band member 38 with the elongated slots 18 and 20
20 and the vertical upper extending bridge portion 30 to thereby stiffen the connector plate 16 against movement traverse to a plane X, Z centrally aligned with a circumference of the hip engaging unit 10, see Fig. 1. The connector plate 16 is formed from a flexible plastic material, such as low-density polyethylene or polypropylene and permits a

greater degree of flex of the connector plate 16 in a direction lying across the plane centrally aligned with the circumference of the hip engaging unit 10. Such an arrangement helps stabilize and prevent relative rotation of the first and second hip engaging members 12 and 14. The aperture 32 further creates a convenient handle that permits a care provider to firmly grasp the rear of the hip engaging unit 10 to provide support for the patient as he/she is acclimatizing himself/herself to the use of this orthosis. An anchor location 37 can be formed on either of the hip engaging members as will subsequently be described. Further details of features of the hip engaging unit 10 can be found in U.S. Patent No. 5,830,168, which is incorporated herein by reference.

Referring to Fig. 1 and Fig. 5, the hip engaging unit 10 is disclosed with an anchor location 37 on the first hip engaging member 12 for adjustably securing a support plate 40 having a curved securement portion 42 and a straight distal portion 44. As shown in Fig. 4, the anchor location 37 is located on the hip engaging member 14. The anchor location will be adjacent the patient's hip socket that was replaced. The first hip engaging member 12 includes a metal anchor plate 46, such as aluminum, which is secured on an interior skin of the rigid plastic shell of the first hip engaging member 12. A fastener 48 can lock the anchor plate 46 to the rigid hip engaging shell. A pair of elongated slots 50 and 52 on the securement portion 42 can receive respective fasteners or bolts 54 and 56. These fastener bolts can be screwed into threaded bores 55 and 57 in the anchor plate 46 and when loosened permit the curved securement portion 42 to radially slide in a vertical plane relative to the hip engaging member 12 and the anchor plate 46 to thereby permit an adjustment of the position of the distal portion 44 relative to the leg appendage of the user. Thus, the dotted lines in Fig. 5 disclose such an

adjustment. This adjustment prevents impingement of the orthosis on the hip of the patient and provides a custom fit for full figure patients.

As can be appreciated, the straight distal portion 44 can also have elongated slot apertures 58 and 60 to permit a relative connection to a hinge member to be subsequently described. The support plate 40 can be made from a relatively heavy gauge aluminum or other material to provide adequate strength.

Since the support plate 40 can be appropriately adjusted by sliding its position relative to its anchored position on the hip engaging unit 10, the distal position can be appropriately positioned for linking with an appended orthotic member which can be attachable to a user appendage. In the embodiment disclosed herein, the user appendage is a leg, but as can be readily appreciated, with an appropriate reversing of position, the support plate 40 could also extend vertically upward to permit a linking with an appended orthotic member for supporting an arm, shoulder, etc. The fastening structure of the elongated slots 50 and 52 with the fastener bolts 54 and 56 enables an adjustable movement relative to the anchor location 37 to permit sliding movements of the distal end 44 towards and away from a user. When the fastener bolts 54 and 56 are appropriately fastened to the anchor plate 46 that can have threaded bore holes for receiving the fastener bolts 54 and 56, the plastic shell of the hip engaging member is captured in a sandwich fashion to provide additional strength and to distribute the appropriate load over a wider area of the hip engaging unit 10.

As can be seen from Figs. 1-3 and Figs. 6-8, an adjustable hinge unit 70 can be connected to the distal portion 44 of the support plate 40. The adjustable hinge unit 70 provides a controlled three-dimensional range of movement to permit a range of flexion

and also abduction and adduction. Various forms of orthopaedic hinge assemblies have been utilized to provide an adjustable range of movement about an axis. An example of an orthopaedic hinge assembly for use with this leg brace can be found in U.S. Patent No. 5,460,599, which is incorporated herein by reference. Another example can be found in U.S. Patent No. 5,421,810, which is also incorporated herein by reference. The adjustable hinge unit 70 of the present invention employs a hinge member 72 having a relatively compact profile and an adjustable range of movement to control flexion and extension of the appendage about a first rotational axis 74. As shown in Figs. 1-3, the adjustable hinge unit is disclosed in a hip orthosis. While the hinge member 72 is preferably of the type disclosed in U.S. Patent No. 5,460,599, other hinge members can be utilized to control the amount of flexion and extension in the present invention.

The hinge member 72 includes a housing structure 76 that can support the rotational movement of a pair of flat disc adjuster members 46 and 48, see Fig. 8. These adjuster members 46 and 48 have peripherally complementary indentations or gear teeth that can be adjustably fastened together or locked by a fastener member (not shown) that can adjustably extend inward or outward in a radial direction from the first rotational axis 74 of the hinge member 72. Accordingly, adjustment of indicator tabs 73 and 75 can adjust the range of flexion movement by moving arcuate openings (not shown) in the adjuster members that receive a stop member (not shown) to define the limited range of movement.

The housing member 76 can further support a support post 78. The support post 78 is radially offset from the first rotational axis 74 and can provide, approximately at its distal end, a universal joint 80. The universal joint 80 is connected to a lever arm 82. In

the embodiment of the invention shown in Figs. 6-8, the lever arm 82 can include a turn buckle 84 that enables the length of the lever arm 82 to be adjusted along its longitudinal axis so that it can be shortened or lengthened. The lever arm 82 has at its other end a second universal joint 86 which is mounted on the distal end of a support post 88. The support post 88 extends upward from a second housing member 90. Depending on whether the adjustable hinge unit 70 is to serve a left or right leg of the patient, the location of the support post 78 can be changed. On either side, the support post 78 is radially offset from the first rotational axis 74 so that the effective distal end of the lever arm 82 is displaced and causes relative movement of the support post 88.

The first housing member 76 can be adjustably mounted to the distal end of the support plate 40. Elongated slots 58 and 60 can receive fastener bolts 92 and 94, respectively, for securement of the hinge member 72 to the support plate 40. Interconnecting the first housing member 76 and the second housing member 90 is an articulated or pivotal joint member 96 with a second axis of rotation 95 that is offset by approximately 90° to the first axis of rotation 74 of the hinge member 72. While 90° is the preferred offset angle, the present invention can utilize other angles, since the purpose of the adjustable hinge unit 70 is to control both flexion and extension about one axis, while controlling adduction and abduction about a second axis in a relative compound motion.

As shown in Fig. 7, the length of the lever arm 82 permits the plate or bar 98 to be relatively co-planar with a support plate 40 when there is 0 degrees of flexion. This could be equivalent, for example, to the alignment shown in Fig. 1 and Fig. 3. As the degree of flexion increases, such as shown in Figs. 2 and 8, the bar 98 with an appendant

orthotic member attached to the thigh and knee area of the user will rotate about the first rotational axis 74 of the hinge member 72. Since the point of attachment of the lever arm 82 is offset from the rotational axis 74, there will be a displacement of the lever arm 82. Since the lever arm 82 has been adjusted by the turnbuckle 84 and the length of the lever arm 82 is fixed after the adjustment, there will be a rotation about the second rotational axis 95 of the pivotal joint member 96 causing either abduction or adduction, depending upon the particular setting of the length of the lever arm 82. Since a hip can be particular susceptible to posterior dislocation when it is flexed past 90 degrees, internally rotated and abducted, the amount of abduction can be controlled along with the range of flexion. Thus, the respective support posts 78 and 88 can provide a fixed distance along with the adjustable lever arm 82. The first housing member 76 and the second housing member 90 which are connected to the pivotal joint member 96 are the other components of the linkage assembly that can control the adduction and abduction of the orthotic brace.

Thus, the adjustable linkage extension system extending across and connected on both sides of the pivotal joint member 96 includes the lever arm 82 that can be adjusted in length to control the movement of the pivotal joint member 96. As can be appreciated, the lever arm 82 can be adjusted in other ways than a turnbuckle 84. The turnbuckle 84 provides minute adjustments but a series of apertures or holes could be provided in a lever arm or a series of replaceable link arms to provide fixed increments of adjustment. Additionally, if desired, the universal joints 80 and 86 could be spring-biased to float on the respective support posts. The particular configuration of the lever arm 82 can be further varied in order to accommodate the profile and size of the pivotal

joint member 96. For example, there could be bowed configuration to the lever arm 82 to maintain a low profile. A removable cap or cover can be attached to the lever arm 82 to deflect contact. As shown in Fig. 8, support bar 98 is rotated rearward in abduction by as much as 45° about the second axis of the pivotal joint 96, as shown by arrow “a”
5 as the flexion is rotated 90° about the first rotational axis 74 of the hinge member 72. This compound motion can be appropriately adjusted by the care provider by adjusting and setting the index tabs 73 and 75 and by turning the turnbuckle 84 to precisely set the permissible range of flexion and abduction required by the specific patient.

An alternative adjustable hinge assembly 170 is shown in Figs. 11 and 12. The
10 hinge assembly 170 includes an adjustable hinge member or unit 172 that can support a rotational movement to control flexion and extension about a central axis A-A. The extent of rotational movement can be set in a conventional manner. The hinge member 172 is relatively compact in profile and is connected to the support plate 40.

Aligned with the axis A-A, a pivotal joint member 174 is mounted above the
15 hinge member 172 and is connected by an arm member 176 to the bar 98. The arm member 176 rotatably mounts a follower member such as a roller 178 that rotates about a shaft journaled on the arm member 176. A cam member 180 having a sloping cam surface engages the roller 178 and defines a range of abduction and adduction as the hip joint flexes and extends. The cam member 180, as shown, has a fixed predetermined
20 cam surface. However, the supporting ring 182 could be rotatable to permit an adjustment with the cam surface appropriately designed. Alternatively, a set of modular combinations (not shown) of different ring and cam profiles can be provided and mounted for a particular patient range of abduction and adduction.

As shown in Fig. 11 by the phantom lines of bar 98, the combination of roller 178 and cam member 180 rotates the bar 98, about the pivotal joint member 174, traverse to the plane of rotation of the hinge member 172.

As further shown in Fig. 1, the support bar 98 also includes a pair of elongated slots 100 and 102. Fastener bolts 104 and 106 can be adjustably mounted within the elongated slots 100 and 102 to attach an appendant orthotic member 120, such as a leg restrainer in the environment of the hip orthosis 200. The attachment of the hip engaging unit 10 and the appendant orthotic member 120 provide two anchor points on the user's body relative to the patient's hip joint, while the support plate 40, adjustable hinge unit 70, and support bar 98 cooperatively define an adjustable positional connector relationship between the hip engaging unit 10 and the appendant orthotic member 120.

As can be appreciated, if there is an uncontrolled relative rotation of the hip engaging unit 10 or of the appendant orthotic member 120, the desired control for flexion and abduction or adduction may be compromised. The hip conforming configuration of the first and second hip engaging members 12 and 14 assist in locking the hip engaging unit 10 about the pelvic region of the user. A leg restrainer that basically encircles only a thigh portion of the user's leg will primarily be engaging soft tissue and may permit a relative rotation about the thigh. The additional amount of contractive force that can be inserted against the patient's thigh is limited by the comfort of the patient so that conventional restrainers that grasp only the thigh portion may permit some undesirable rotation. The appendant orthotic member 120 of the present invention has been heat formed to extend diagonally about and to be fixed to a human

appendage, such as the leg, with a contact on the outer thigh and an inner contact adjacent the inside of the knee portion of the user. As can be appreciated, the knee portion in most users provides a greater immediacy of contact, since the skeletal structure of the knee joint has less fat or soft tissue.

5 Thus, by having one side of the appendant orthotic member 120 longitudinal displaced along the leg appendage of the user from an opposite side of the appendant orthotic member, it will provided correspondingly longitudinally displaced fixation points to prevent rotational displacement. The appendant orthotic member 120 is bifurcated into a first section 122 and a second section 124. The second section 124 is
10 connected to an injection molded Nylon® slotted anchor plate or housing 126. The first section 122 and second section 124 are formed from a relatively rigid plastic of an acrylic modified PVC, such as Kydex® sold by Kleerdex, Inc.

 The first section 122 and second section 124 have relatively elongated band configurations that collectively form a diagonal cylindrical configuration when attached
15 together. The distal ends of the first and second sections relative to the anchor plate 126 are adjustably connected together to permit sizing to the particular dimension of the leg appendage. The distal end of the second section 124 is enlarged to a somewhat oval configuration 128 having a central elongated slot 130 with an appropriately textured friction perimeter band 132 of the same type as described on the hip engaging unit 10.
20 The distal end of the first section 122 has an aperture 134 that can receive a plastic male fastener 136 that can be secured to a female fastener 138. The matching surface of the distal end of the first section 122 extending around the aperture 134 can have a complementary friction textured perimeter (not shown) to provide a secure compression

friction fit with the textured perimeter band 132. The proximal end of the first section 122 is formed into an insertion tongue member 140 for mounting within a slot 142 in the anchor plate 126. A buckle and strap closure unit 144 retains the tongue member 140 within the slot opening 142 of the anchor housing 126. The buckle member 146 is
5 anchored to the anchor housing 126. A male member 150 on the strap 148 can removably lock to the buckle member 146 on strap 147 and the strap 148 portion can have an appropriate nap portion that will affix to a hook strip 152, such as a Velcro® fastener arrangement.

Likewise, individual hook patches 154 can be adhered to the inner surface, for
10 example, of the anchor plate housing 126 and also to the inner surfaces of the first section 122 and second section 124 whereby neoprene pads 154 and 156 can be held in place to provide cushioning when the first section 122 is hooked into the anchor housing 126 and forms with the second section 124 the appendant orthotic member 120 that will extend diagonally about the human leg. Extra padding can be provided over distal ends
15 that bear against the knee. Since the elongated bands of relatively rigid plastic that form the first section 122 and second section 124 extend diagonally, they provide a firm anchoring on the inside of the knee and the outside of the thigh to prohibit relative rotation. However, there is sufficient flex in the appendant orthotic structure 120 to permit the user to remove the connection to the leg when the male member 150 is
20 released from the buckle member 146. The adjustment to the size of the leg is made by the distal end joint adjustment, and the buckle member 146 only holds the tongue 140 in a fixed position.

An additional advantage of the particular design of the appendant orthotic 120 is that the diagonal configuration permits the patient to be more comfortable when seated, as shown in Figs. 2 and 3, since it is displaced from the seat and crotch area of the user. Thus, the patient is not necessarily directly sitting on the second section 124. If the
5 adjustable hip orthosis 200 is worn under clothing, for example, by a patient with a dress or gown, the ability to use a toilet seat is provided without removing the orthosis, while still maintaining a sanitary condition. Since a patient will experience greater comfort while his range of motion and movement will be precisely controlled, the patient will be encouraged to wear the orthosis during the prescribed time period to prevent dislocation
10 of a hip. As can be appreciated, the post-operative treatment of a patient can frequently extend from six weeks to six months, and patients who do not wear their orthoses will be more susceptible to problems.

The preferred embodiment disclosed herein incorporates the contributory benefits of each of the modular components to provide a precisely controllable
15 orthotic solution to the post-operative treatment of a patient with hip arthroplasties. As can be appreciated, however, the individual component parts can also be utilized in other configurations of orthoses to realize the economical advantages of a pre-fabricated orthosis for a patient.

In the appended claims, the invention will be described in accordance with the
20 sixth paragraph of 35 U.S.C. § 112 only when the claim terminology of "means" is expressly incorporated into the body of the claims.

Those skilled in the art will appreciate that various adaptations and modifications of the just-described preferred embodiment can be configured without departing from the scope and spirit of the invention. Therefore, it is to be understood that, within the scope of the appended claims, the invention may be practiced other than
5 as specifically described herein.